STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155103	A. BUILDING _____ B. WING _____	R 03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRONWOOD HEALTH AND REHABILITATION CENTER	**1950 RIDGEDALE RD SOUTH BEND, IN 46614**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on January 14, 2014.

This visit was in conjunction with the PSR to the Investigation of Complaint #IN00144084 completed on February 12, 2014.

Survey dates: March 24, 25 and 26, 2014.

Facility Number: 000042
Provider Number: 155103
AIM Number: 100291540

Survey Team:
Shelly Miller-Vice, RN TL
Julie Baumgartner, RN

Census bed type:
SNF/NF: 105
Total: 105

Census payor type:
Medicare: 10
Medicaid: 81
Other: 14
Total: 105

Ironwood Health and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2, in regard to the PSR to the Recertification and State Licensure Survey.

Quality Review completed on March 27, 2014, by Brenda Meredith, R.N.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE